Annapolis Community Health Partnership

Maryland Community Health Resources Commission

April 2, 2015

ACHP

- Collaboration between Anne Arundel Medical Center (AAMC) and Housing Authority of the City of Annapolis (HACA)
- Insertion of a community health resource in a public housing unit ("MB") to serve residents and the surrounding community
  - Primary care medical services at reduced cost
  - Navigational services at no cost: care coordination, coaching, education, advice and support

ACHP Structure

- **One medical practice**, < 1,000 sq feet:
  - MD
  - RN Care Coordinator
  - Office assistant/medical assistant (bilingual)
- **Many partners:**
  - HACA congregant program, AAMC care management and social work, contracted CHWs, AskAAMC, behavioral health resources, medical specialist community
- **Infrastructure: AAMC's** integrated electronic medical record

What ACHP Has Accomplished

- Expanded and Filled Service Capacity
  - Provided direct primary care services to 1,119 unduplicated patients since opening in October 2013
  - Engaged >50% of MB residents in direct primary care services, provided navigational services to many more
- Assured Quality of Care
  - Reduced medical 911 calls, ED visits, admissions and readmissions from MB

More stats: ALL MB **RESIDENTS** (not necessarily ACHP patients)
MB Opened in October 2013

	1/1/13 - 6/30/13	7/1/13 - 12/31/13	1/1/14 - 6/30/14	7/1/14- 12/31/14
Readmission Events	11	14	6	1
Admission Events	49	47	37	26
ED visits	n/a	103	87	88
Medical 911 calls	n/a	87	111	83

Lessons Learned Since Opening

- Navigational services *are at least as important* as medical services in reducing preventable utilization.
- Longitudinal relationships allow us to move from crisis intervention to *prevention and self-management*.
- Building trust requires tolerance, respect, perseverance and *listening*.

Getting Insurance Coverage or Access to Care Does Not Confer Instant Health Literacy

- Tales from the frontline:
  - The newly insured
  - The new immigrant
  - The new entrant to primary care

ACHP's Year 3 Work Plan:
Consolidating and Building Upon Early Success

- Reduce prevalence of risk factors for developing chronic disease, and reduce the risk of complications in those with chronic disease
- Increase community resources for health
- Reduce preventable ED visits and hospitalizations
- Reduce unnecessary costs in healthcare

1)Reduce risk factors for chronic disease and risk for complications of chronic disease

- 100% of patients age ≥ 18 screened for tobacco use.
  - Improve provision of interventions for those screening positive by 20%
- 100% of patients age ≥12 screened for depression
  - Improve provision of interventions for those screening positive by 20%
- 100% of patients age ≥18 screened for abnormal BMI
  - Improve provision of interventions for those screening positive by 20%

Risk Factor Reduction, cont'd

- Improve control (<140/90) of blood pressure in hypertensive patients age 18-85 by 20%
- Reduce by 20% the percentage of diabetics age 18-75 with A1C > 9.0
- Improve by 20% the percentage of diabetics with an annual retinopathy screen.
- Improve by 20% the percentage of diabetics with an annual foot exam.

How ACHP Will Accomplish This

- EMR workflow and tools
  - Point-of-care reminders
  - Population registries and dashboards
- Patient outreach and follow up
  - Interventions provided at clinic
  - Interventions provided by network of community specialists, educators, peer-to-peer coaching

2) Increase Community Resources for Health

- Provide diabetes self-management workshops to at least 20 high-risk patients
- Provide COPD self-management workshops to at least 20 high-risk patients
- Provide one-on-one coaching to at least 10 individuals seeking help to cease tobacco consumption
- Implement Referrals for Recovery (RforR) to ensure timely evaluation for those with urgent need for behavioral health services

How ACHP Will Accomplish This

- AAMC nurses have been trained to lead diabetes workshops
- AAMC respiratory therapists and pharmacists will lead the COPD workshop
- AAMC cancer prevention specialists will provide one-on-one coaching on site.
- Funding has been provided to implement RforR, a program that involves a network of 6 behavioral health providers.

3) Continue to Reduce Preventable ED Visits and Hospitalizations

- Implement program of identifying "medically homeless" individuals in the ED and referring them to MB for care.
- Implement changes in hours of operation at MB clinic to better meet population needs

How ACHP Will Accomplish This

- Engage ED care managers and staff as well as key community specialty providers to refer "medically homeless" patients to MB, particularly those who are uninsured, underinsured and/or Spanish-speaking.
- Examine volume patterns of demand, no-show rates and walk-ins to determine what change of hours would optimize utilization.

4) Reduce Unnecessary Costs in Healthcare

- Perform quarterly assessment of ED visits by MB residents to assess reasons for visit.
- Promote use of the MB clinic for services that can easily be performed there.

How ACHP Will Accomplish This

- Configure report from hospital warehouse data that blindly lists “reason for visit” of patients from address of MB.
- Review report to determine which types of ailments could have been addressed at MB (e.g. UTI, cerumen impaction, COPD exacerbation).
- Use local marketing in 3 new ways to increase awareness and promote use of the clinic as an alternative to the ED.

Projected Year 3 Budget Expenditures

- Total annual HEZ funding to ACHP is $200,000. This offsets the physician's salary and fringe benefits.
- Remaining costs of staffing, medical supplies and equipment, vaccines, office supplies and equipment, management, communication hardware, EMR, et cetera are covered by AAMC.

ACHP Partnerships and Opportunities

- Faith-based Community
- Behavioral Health
  - Arundel Lodge
  - Other behavioral health providers
- Private Donations
  - Individual
  - Corporate, e.g. Charm City Run
- External Funding Partnerships
  - Stulman Foundation
  - Pending Grants

"The power of community to create health is far greater than any physician, clinic or hospital."

Mark Hyman